Wellmark Iowa

An Independent Licensee of the Blue Cross and Blue Shield Association

B E N E F I T S C E R T I F I C A T E

Employer Group Retiree Program

State of Iowa
Program N

Notice to Buyer
This certificate may not cover all of your medical expenses. THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If you are eligible for Medicare, review the Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare (CMS Product No. 02110) available at *www.medicare.gov* or *available* from us, by calling 800-336-0505.

NOTICE OF PROTECTION PROVIDED BY IOWA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Iowa Life and Health Insurance Guaranty Association (the "Association") and the protection it provides for policyholders. This safety net was created under Iowa law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Iowa law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

Life Insurance
- $300,000 in death benefits
- $100,000 in cash surrender and withdrawal values

Health Insurance
- $500,000 in basic hospital, medical-surgical or major medical insurance benefits
- $300,000 in disability income protection insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities
- $250,000 in annuity benefits, cash surrender and withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000. Special rules may apply with regard to hospital, medical-surgical and major medical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. If coverage is available, it will be subject to substantial limitations and exclusions. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements under Iowa law.

To learn more about the Association and the protections it provides, as well as those relating to group contracts or retirement plans, please visit the Association's website at www.ialifega.org, or contact:

Iowa Life and Health Insurance
Guaranty Association
700 Walnut Street, Suite 1600
Des Moines, IA 50309
(515) 248-5712

Iowa Insurance Division
330 Maple Street
Des Moines, IA 50319
(515) 281-5705

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as AM Best Company, Fitch Inc., Moody's Investors Service, Inc., and Standard & Poor's. That information may be accessed from the "Helpful Links & Information" page located on the website of the Iowa Insurance Division at www.iid.state.ia.us.

The Association is subject to supervision and regulation by the Commissioner of the Iowa Insurance Division. Persons who desire to file a complaint to allege a violation of the laws governing the Association may contact the Iowa Insurance Division. State law provides that any suit against the Association shall be brought in the Iowa District Court in Polk County, Iowa.

Insurance companies and agents are not allowed by Iowa law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Iowa law, then Iowa law will control.

Contents

1. Important Information

The policyholder's group health care coverage is called Employer Group Retiree Program. This product was developed to help you pay for some of your health care expenses not paid in full by Medicare. This coverage only pays for those services accepted and approved by Medicare with the exception of benefits for medically necessary emergency care outside the United States.

Understanding This Coverage

To understand the benefits of this Employer Group Retiree Program benefits certificate, you must first understand your Medicare benefits. Therefore, it is very important that you also carefully read *Medicare & You*, the official government handbook. If you do not have a Medicare handbook, you may order one by calling your Social Security office.

Medicare benefits are divided into two categories: Medicare Part A and Medicare Part B.

Medicare Part A

Medicare Part A helps pay for inpatient hospital care, inpatient skilled care in a nursing facility, home health care and hospice services. We offer you supplemental benefits in these categories as stated in the *Benefits* section.

Medicare Part B

Medicare Part B helps pay for physician services, outpatient hospital services, home medical equipment, and a number of other medical services and supplies that are not covered by Medicare Part A. We offer you supplemental benefits in all these categories as stated in the *Benefits* section, with the addition of benefits for medically necessary emergency care outside the United States.

The Way Payment Works

When a physician or supplier agrees to accept the charge approved by Medicare as the most he or she will collect for covered services, he or she is said to accept assignment. All physicians who participate in the Medicare program agree to accept assignment. If you are not sure if your physicians participate in the Medicare program, ask them and they will tell you.

If a physician does not accept assignment, he or she may collect more than Medicare's approved amount. When this happens, you are responsible for the difference between the approved amount and the billed amount.

If your provider accepts assignment, we will send our payment directly to that provider. If your provider does not accept assignment, we send our payments to you, or, in the event of your death, to your estate.

Filing Claims

You do not need to file a claim for any services. By law, physicians or other suppliers must fill out claim forms for you and send them to Medicare even if they do not accept assignment. However, you should always make sure your physician knows that you have supplemental coverage with us.

Out-of-State Services

When you receive health services in your home state, Medicare will automatically send your claim to us. If you receive health services outside your home state, the provider will submit your claim to the Medicare office in that state. After the office processes the claim, you will receive an Explanation of Medicare Benefits (EOMB). If the Notes section of the EOMB says that the information is being

sent to your private insurer, we will automatically receive the EOMB.

If the EOMB does not say your private insurer is receiving the information, you need to send the EOMB to us so we can process your benefits. Be sure your Wellmark Blue Cross and Blue Shield identification number and mailing address are shown accurately on the EOMB form. You do not need to complete a claim form; just send the EOMB, and keep a copy for your own records. Send it to:

Wellmark Blue Cross and Blue Shield of Iowa
Employer Group Retiree Claims
1331 Grand Ave., Station 5C139
Des Moines, IA 50309-2901

Interpreting This Certificate

We will interpret the provisions of this certificate and determine the answer to all questions that arise under it. We have the administrative discretion to determine whether you meet our written eligibility requirements, or to interpret any other term in this certificate. If any benefit described in this certificate is subject to a determination of medical necessity, unless otherwise required by law, we will make that factual determination. Our interpretations and determinations are final and conclusive.

2. Benefits

Medicare Part A helps pay for most but not all of the services you receive in a hospital or nursing facility or from a home health agency or hospice program. Medicare Part B helps pay for some but not all doctor services and other medical services and supplies that are not covered under Medicare Part A. Your coverage with us helps pay for some of the remaining health care expenses.

Benefit Period

A benefit period under Medicare Part A is used to count the number of days you are covered for medically necessary services in a hospital or other facility primarily providing skilled or rehabilitation services.

There is a limit on how many days of hospital or nursing facility care Medicare helps pay for in each benefit period. However, it is possible to renew a benefit period. When your benefit period is renewed, your Part A protection is also renewed. Renewing a benefit period means that you begin a new benefit period.

During a benefit period, Medicare will help you pay for medically necessary covered services when you are an inpatient in a hospital for 90 days. If you are in the hospital for more than 90 days, then Medicare offers 60 lifetime reserve days you can use to help meet expenses.

When Benefit Periods Begin and End

A benefit period begins on the first day you enter a hospital or nursing facility as an inpatient.

A benefit period ends after you have been out of the facility for 60 days in a row (including the day of discharge).

A benefit period starts over when you reenter a hospital or nursing facility more than 60 days after your last discharge.

The following are two examples of how the benefit period works. The first example shows when the benefit period is renewed. The second example shows when the benefit period is not renewed.

Example 1

(Benefit Period Renewed)
Let's say you enter the hospital on January 15. You are discharged on January 25. You use 10 days of your first benefit period. You are not hospitalized again until July 20.

Since more than 60 days passed between your hospital stays, you begin a new benefit period. This means your Medicare Part A coverage is completely renewed. Therefore, you have 90 eligible days to use in the new benefit period.

Example 2

(Benefit Period not Renewed)
Let's say you enter the hospital January 15. You are discharged January 25. As before, you use 10 days of your first benefit period. However, you are then readmitted to the hospital on February 20.

Since less than 60 days passed between hospital stays, your benefit period is not renewed. You are still in your first benefit period. The first day of your second admission (February 20) is counted as day 11 of hospital care in that benefit period. Therefore, you have 80 remaining eligible days in that benefit period. You will not begin a new benefit period until you have been out of the hospital (or nursing facility) for 60 consecutive days.

Medicare Part A Coinsurance

We will help pay for some of the expenses while you are in the hospital by supplementing Medicare's coverage.

Days 61-90
We pay the Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

Days 91-150
We pay the Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day you use.

Days beyond 150
Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, we pay the Medicare Part A eligible expenses for hospitalization at the applicable prospective payment system (PPS) rate, or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept our payment as payment in full and may not bill you for any balance.

Medicare Blood Deductible

We pay, under Medicare Parts A and B, for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

Medicare Part B Coinsurance

We pay the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible and subject to any office visit or emergency room visit copayment amounts that you are responsible for.

Hospice Care

We pay all of the copayment and/or coinsurance amounts of Medicare eligible expenses under Part A for hospice and respite care.

Medicare Part A Deductible

We pay all of the Medicare Part A inpatient hospital deductible amount per benefit period.

Nursing Facility Days 21-100

We pay for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled care in a nursing facility eligible under Medicare Part A.

Medically Necessary Emergency Care in a Foreign Country

To the extent not covered by Medicare, we pay for eighty percent (80%) of the billed charges for Medicare eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, subject to a calendar year deductible of two hundred fifty dollars ($250) and a lifetime maximum benefit of fifty thousand dollars ($50,000). The emergency care must have been eligible for coverage by Medicare if provided in the United States, and the care must have begun during the first sixty (60) consecutive days of each trip outside the United States. For purposes of this benefit, emergency care means care needed immediately because of an injury or an illness of sudden and unexpected onset.

3. Services Not Covered

We will not allow benefits for:

- services not allowed by Medicare as benefits, except as stated in the *Benefits* section of this certificate;
- services denied by Medicare, except as stated in the *Benefits* section of this certificate;
- deductibles or coinsurance amounts, not covered by Medicare, except as stated in the *Benefits* section of this certificate; and
- services that would duplicate benefits provided by Medicare.

If you have any questions after reading *Medicare & You* and this Employer Group Retiree Program certificate, please call us at 800-245-6106. Remember, we're here to help you.

4. Appeals

Right of Appeal

You have the right to one full and fair review in case of a denied or reduced claim, or an adverse benefit determination. An adverse benefit determination is one that denies or reduces benefits.

How to Appeal

You or your authorized representative, if you have designated one, may appeal a reduced or denied benefit within 180 days from the date you are notified of our adverse benefit determination by submitting a written appeal to Wellmark. See *Authorized Representative*.

What to Include in Your Appeal

You must submit all relevant information with your initial appeal, including the reason for your appeal. This includes written comments, documents, or other information in support of your appeal. You must also submit:

- Date of your request.
- Your name (please type or print), address, and if applicable, the name and address of your authorized representative.
- Member identification number.
- Claim number from your Explanation of Benefits, if applicable.
- Date of service in question.

Where to Send Appeal

Wellmark Blue Cross and Blue Shield of Iowa
Appeals
1331 Grand Avenue, Station 5W189
Des Moines, IA 50309-2901

Review of Appeal

Your request for an appeal will be reviewed only once. The review will take into account all information regarding the adverse decision whether or not the information was presented or available at the initial determination. Upon request, and free of charge, you will be provided reasonable access to and copies of all relevant records used in making the initial decision.

The review will not be conducted by the original decision makers or any of their subordinates. The review will be conducted without regard to the original decision. If a decision requires medical judgment, we will consult an appropriate medical expert who was not previously involved in the original decision. If we deny your appeal, in whole or in part, you may request, in writing, the identity of the medical expert we consulted.

Decision on Appeal

The decision on appeal is the final internal determination. Once a decision on appeal is reached, your right to appeal is exhausted.

You will be notified in writing of our decision. An appeal of a denied or reduced claim will be decided within 60 days.

Legal Action

You shall not start legal action against us until you have exhausted the appeal procedure described in this section.

External Review Process

If you have exhausted our internal appeal process regarding a denial or reduction of benefits involving medical necessity, appropriateness of services or supplies, or experimental or investigational services or supplies, you or your authorized representative may request an external review of our decision through the Iowa Commissioner of Insurance by completing an External Review Request Form.

You will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on your request for external review.

Requests must be filed in writing at the following address, no later than four months after you receive notice of the final adverse benefit determination:

Iowa Division of Insurance
330 Maple Street
Des Moines, IA 50319-0065

5. Your Certificate

Contract

The conditions of your coverage are defined in your contract. Your contract includes:

- Any application you submitted to us or the policyholder for coverage.
- Any agreement or group policy we have with the policyholder.
- Any application completed by the policyholder.
- This benefits certificate and any amendments.

Coverage Eligibility

You are eligible for this coverage if you are enrolled in both Medicare Part A and Medicare Part B and satisfy the conditions of eligibility established by the policyholder in its group employee benefit plan.

Release of Information

You have agreed in your application for coverage to release any necessary information requested about you so we can process claims for benefits.

You must allow any provider, facility or their employee to give us information about a treatment or condition. If we do not receive the information requested, or if you withhold information in your application, your benefits may be denied. If you fraudulently use your coverage or misrepresent or conceal material facts in your application, then we may terminate your coverage under this health plan.

Term and Renewal

This certificate will be in force for one month after the effective date, provided we have received and accepted your application and payment. If your premium is paid when due and your certificate is not terminated by you, the policyholder, or us, then we will automatically renew your certificate each month.

Premiums

You must pay us the applicable premiums in advance of the due date assigned for the duration of your certificate. The payment must meet the premium requirements for that period.

Premium Changes

The amount of your periodic premium payment will change as otherwise provided in your certificate and from time to time based on changes in your coverage, including but not limited to, changes in benefits, payment obligations (such as deductible, coinsurance, and copayments), your age, or other factors that require adjustments to the total premium. These changes may occur at times other than an annual or other certificate renewal. Premium changes will be reflected in your premium invoice or other notification.

Automatic Payments

If you elected to authorize automatic premium withdrawals from a deposit account, the automatic withdrawal will change periodically to correspond with the applicable premium. Your authorization for automatic premium withdrawals shall include authorization for automatic withdrawal of any changed amount unless you call or provide your bank with written notice not less than three business days before a scheduled withdrawal to stop the payment. If you call your bank to stop payment, you may be required to provide a written request within 14 days after your call. You will be responsible for any fee assessed by your bank for stop-payment orders that you make.

Medicare Deductible and Coinsurance Changes

The deductible and coinsurance amounts to be paid by us will automatically change when Medicare's deductible and coinsurance change. This usually happens on January 1 each year.

Authority to Terminate, Amend, or Modify

The policyholder has the authority to terminate, amend, or modify the coverage described in this certificate at any time. We also have this authority. Any amendment or modification will be in writing and will be as binding as this certificate. If your coverage is terminated by the policyholder and is not replaced, or if your coverage is terminated by us for any reason other than nonpayment of premium or material misrepresentation, you will be offered certain continuation options as described in *Continued Coverage* in this section of this certificate.

When Coverage Ends

Your coverage will end immediately if any of the following occurs:

- You or the policyholder fraudulently misrepresents or conceals material facts in the application. If this happens, we will recover any claim payments we made, minus any premium paid.
- You fail to pay the monthly premium when due.
- You or the policyholder terminates this certificate by giving written notice of termination to Wellmark Blue Cross and Blue Shield of Iowa at least 30 days before the termination date.
- You fail to satisfy the requirements for eligibility. See *Coverage Eligibility* earlier in this section.
- We terminate this certificate by terminating the agreement or group insurance policy we have with the policyholder.

Continued Coverage

If your coverage is terminated by the policyholder and is not replaced, or if your coverage is terminated by us for any reason other than nonpayment of premium or material misrepresentation, we will offer you:

- an individual Medicare supplement policy that continues the benefits of this certificate; or
- a standardized, individual Medicare supplement policy currently offered by us that has benefits comparable to those in this certificate.

If you terminate this Employer Group Retiree Program coverage, we will offer you:

- an individual Medicare supplement policy that continues the benefits of this certificate;
- a standardized, individual Medicare supplement policy currently offered by us that has benefits comparable to those in this certificate; or
- at the option of the policyholder, continuation of coverage under the group plan.

If the policyholder decides to purchase Employer Group Retiree Program coverage from another carrier and replaces this Employer Group Retiree Program coverage, the new carrier must offer coverage to all persons covered under the replaced group coverage on its date of termination. Coverage under the new policy will not result in any exclusion for preexisting conditions that would have been covered under the group certificate being replaced.

Effects of Termination

If this certificate is terminated because of your or the policyholder's failure to pay us premiums when due, we will not pay any benefits under this certificate after the termination date.

If your certificate is terminated for misrepresentation or the concealment of material facts:

- We will not pay for any services or supplies provided after the date the certificate is terminated.
- We will retain legal rights, including the right to sue based on concealment or misrepresentation.
- We may, at our option, declare the certificate void.

If your certificate is terminated for reasons other than concealment or misrepresentation of material facts, we may stop payment for any services or supplies the day your certificate is terminated.

An exception to this applies in the case of a continuous loss that commenced while this certificate is in force. If you receive covered professional or facility services as an inpatient of a hospital or nursing facility on the date this certificate terminates, payment for these covered services will end on the earliest of:

- the date you are first discharged from the facility following termination of this certificate;
- the date the certificate coverage period would have ended if this certificate had not been terminated– that is, the end of the calendar year during which you were an inpatient in a hospital or nursing facility;
- the date your Medicare benefits are exhausted if no additional benefits would otherwise have been covered under this certificate had it remained in effect; or
- payment of maximum benefits.

Suspension of Coverage Available During Medicaid Eligibility

You may request a suspension of coverage for the period (not to exceed twenty-four (24) months) in which you have applied for and have been determined entitled to medical assistance under Title XIX of the Social Security Act (Medicaid). You must notify us within ninety (90) days after the date you become entitled to such assistance. We shall return to you that portion of the premium paid by you which is attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

If a suspension occurs and you lose entitlement to such Medicaid assistance within twenty-four (24) months, your certificate will be automatically reinstated as of the date your entitlement is terminated if you notify us that you lost Medicaid entitlement. You must notify us within ninety (90) days after the date of such loss, and you must pay the premium attributable to the period, effective as of the date of termination of Medicaid entitlement.

Reinstatement of such coverage:

- will not provide for any waiting period with respect to treatment of pre-existing conditions;
- will provide for coverage substantially equivalent to the coverage in effect before the date of such suspension; and
- will provide for premium classification on terms at least as favorable to you as the premium classification terms that would have applied had the coverage not been suspended.

Subrogation

Right of Subrogation

If you or your legal representative have a claim to recover money from a third party and this claim relates to an illness or injury for which Wellmark provides benefits, Wellmark will be subrogated to you and your legal representative's rights to recover from the third party as a condition to your receipt of benefits.

Right of Reimbursement

If you are injured as a result of the act of a third party and you or your legal representative files a claim under this health plan, as a condition of receipt of benefits, you or your legal representative must reimburse Wellmark for all benefits paid for the injury from money received from the third party or its insurer, to the extent of the amount paid by Wellmark on the claim.

Once you receive benefits under this health plan arising from an illness or injury, Wellmark will assume any legal rights you have to collect compensation, damages, or any other payment related to the illness or injury from any of the following:

- The responsible person or that person's insurer.
- Uninsured motorist coverage.
- Underinsured motorist coverage.
- Other insurance coverage, including but not limited to homeowner's, motor vehicle, or medical payments insurance.

You agree to recognize Wellmark's rights to subrogation and reimbursement. These rights provide Wellmark with a priority over any money paid by a third party to you relative to the amount paid by Wellmark, including priority over any claim for non-medical charges, or other costs and expenses. Wellmark will assume all rights of recovery, to the extent of payment, regardless of whether payment is made before or after settlement of a third party claim, and regardless of whether you have received full or complete compensation for an illness or injury.

Procedures for Subrogation and Reimbursement

You or your legal representative must do whatever Wellmark requests with respect to the exercise of Wellmark's subrogation and reimbursement rights, and you agree to do nothing to prejudice those rights. In addition, at the time of making a claim for benefits, you or your legal representative must inform Wellmark in writing if you were injured by a third party. You or your legal representative must provide the following information, by registered mail, within seven (7) days of such injury to Wellmark as a condition to receipt of benefits:

- The name, address, and telephone number of the third party that in any way caused the injury, and of the attorney representing the third party;
- The name, address and telephone number of the third party's insurer and any insurer of you;
- The name, address and telephone number of your attorney with respect to the third party's act;
- Prior to the meeting, the date, time and location of any meeting between the third party or his attorney and you, or your attorney;
- All terms of any settlement offer made by the third party or his insurer or your insurer;
- All information discovered by you or your attorney concerning the insurance coverage of the third party;
- The amount and location of any money that is recovered by you from the third party or his insurer or your insurer, and the date that the money was received;
- Prior to settlement, all information related to any oral or written settlement agreement between you and the third party or his insurer or your insurer;
- All information regarding any legal action that has been brought on your behalf against the third party or his insurer; and
- All other information requested by Wellmark.

Send this information to:

Wellmark Blue Cross and Blue Shield of Iowa
1331 Grand Ave., Station 5E293
Des Moines, IA 50309-2901

You also agree to all of the following:

- You will immediately let us know about any potential claims or rights of recovery related to the illness or injury.
- You will furnish any information and assistance that we determine we will need to enforce our rights under this health plan.
- You will do nothing to prejudice our rights and interests including, but not limited to, signing any release or waiver (or otherwise releasing) our rights, without obtaining our written permission.
- You will not compromise, settle, surrender, or release any claim or right of recovery described above, without obtaining our written permission.
- If payment is received from the other party or parties, you must reimburse us to the extent of benefit payments made under this health plan.
- In the event you or your attorney receive any funds in compensation for your illness or injury, you or your attorney will hold those funds (up to and including the amount of benefits paid by Wellmark in connection with the illness or injury) in trust for the benefit of Wellmark as trustee(s) for Wellmark until the extent of our right to reimbursement or subrogation has been resolved.

In the event Wellmark deems it necessary to institute legal action against you if you fail to repay Wellmark as required in this health plan, you shall be liable for the amount of such payments made by Wellmark as well as all of Wellmark's costs of collection, including reasonable attorney fees and costs.

You and your covered family member(s) must notify us if you have the potential right to receive payment from someone else. You must cooperate with us to ensure that our rights to subrogation are protected.

Wellmark's right of subrogation and reimbursement under this health plan applies to all rights of recovery, and not only to your right to compensation for medical expenses. A settlement or judgment structured in any manner not to include medical expenses, or an action brought by you or on your behalf which fails to state a claim for recovery of medical expenses, shall not defeat our rights of subrogation and reimbursement if there is any recovery on your claim.

We reserve the right to offset any amounts owed to us against any future claim payments.

Payment in Error

If for any reason we make payments under this certificate in error, we may recover the amount we paid.

Authorized Representative

You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. This authorization must be in writing, signed by you, and include all the information required in our Authorized Representative or Personal Representative Appointment Form. This form is available at *www.wellmark.com* or by calling Wellmark Customer Service.

In a medically urgent situation your treating health care practitioner may act as your authorized representative without completion of the Personal Representative Appointment Form.

An assignment of benefits, release of information, or other similar form that you may sign at the request of your health care provider does not make your provider an authorized representative.

You may revoke the authorized representative at any time, and you may authorize only one person as your representative at a time.

Notice

If a specific address has not been provided elsewhere in this certificate, you may send any notice to Wellmark's home office:

Wellmark Blue Cross and Blue Shield of Iowa
1331 Grand Ave.
Des Moines, IA 50309-2901

Any notice from Wellmark to you is acceptable when sent to your address as it appears on Wellmark's records.

Privacy of Information

We are committed to protecting the privacy of your health information. We will request, use or disclose your health information only as permitted or required by law. Wellmark has issued a *Privacy Practices Notice*. This notice is available upon request or at *www.wellmark.com*.

We will use or disclose your health information for treatment, payment, and health care operations according to the standards and specifications of the federal privacy regulations.

Treatment

We may disclose your health information to a physician or other health care provider in order for such health care provider to provide treatment to you.

Payment

We may use and disclose your health information to pay for covered services from physicians, hospitals and other providers, to determine your eligibility for benefits, to determine medical necessity, to obtain premiums, to issue explanations of benefits to the person enrolled in the health plan in which you participate, and the like. We may disclose your health information to a health care provider or entity subject to the federal privacy rules so they can obtain payment or engage in these payment activities.

Health Care Operations

We may use and disclose your health information in connection with health care operations. Health care operations include, but are not limited to, rating our risk and determining premiums for your health plan; quality assessment and improvement activities; reviewing the competence or qualifications of health care practitioners, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities; medical review, legal services, and auditing, including fraud and abuse detection and compliance; business planning and development; and business management and general administrative activities.

Other Disclosures

We will obtain your explicit authorization for any use or disclosure of your health information that is not permitted or required by law. For example, we may release claim payment information to a friend or family member to act on your behalf during a hospitalization if you submit an authorization to release information to that person.

Legal Action

You shall not start any legal action against us unless you have exhausted the appeal process described in the *Appeals* section.

You shall not bring any legal or equitable action against us because of a claim under this health plan, or because of the alleged breach of this plan, more than two years after the end of the calendar year in which the services or supplies were provided.

Value Added Benefits

Wellmark may from time to time make available to you certain value added benefits for a fee or for no fee. Examples include discounts on

alternative/preventive therapies, fitness, exercise and diet assistance, and elective procedures as well as resources to help you make more informed health decisions.

Nonassignment

Benefits for covered services under this health plan are for your personal benefit and cannot be transferred or assigned to anyone else without our consent. You are prohibited from assigning any claim or cause of action arising out of or relating to this health plan. Any attempt to assign this health plan or rights to payment will be void.

Governing Law

To the extent not superseded by the laws of the United States, this health plan will be construed in accordance with and governed by the laws of the state of Iowa. Any action brought because of a claim under this plan will be litigated in the state or federal courts located in the state of Iowa and in no other.

Time Limit on Certain Defenses

After two years from the effective date of this certificate, no misstatements, except fraudulent misstatements, made by you in the application for this certificate can be used to void your certificate or deny a claim for an illness or injury incurred commencing after the expiration of the two-year period.

No claim for illness or injury commencing after two years from the effective date of this certificate will be reduced or denied on the grounds that the disease or physical condition not excluded from coverage by name or specific description effective on the date of service had existed prior to the effective date of coverage of this certificate.

Disclosure Statement

You hereby expressly acknowledge your understanding that this certificate is a contract solely between you, the plan member, and us, Wellmark Blue Cross and Blue Shield of Iowa. We are an independent corporation operating under a license from the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and Blue Shield Plans. BCBSA permits us to use the Blue Cross and Blue Shield Service Marks in the State of Iowa. However, we are not a contracting agent of BCBSA. You, the plan member, further acknowledge and agree that you have purchased this certificate based upon representations by us and only us. No other person, entity, or organization other than us is accountable or liable to you for any obligations created under this certificate. This paragraph does not create any additional obligations whatsoever on our part other than those obligations created under the provisions of this certificate.

6. Glossary

Accidental Injury means an injury, independent of disease or bodily infirmity or any other cause, that happens by chance and requires immediate medical attention. We will not provide benefits if your accidental injury falls under:

- motor vehicle no-fault plan;
- workers' compensation; or
- employer's liability or similar law, unless prohibited by law. This includes any accidental injury you receive while you were working, while engaged in any activity pertaining to any trade, business, employment or occupation for wage or profit.

Assignment means a provider or supplier agrees to accept Medicare's approved charge as full payment for a service or supply. This does not include any deductible or coinsurance amount you are responsible for paying.

Certificate means this Employer Group Retiree Program benefit document, which was delivered or issued for delivery in Iowa by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa, pursuant to the employer group program sponsored by the policyholder with whom a group insurance policy is in effect with us.

Certificate Coverage Period is the same as a calendar year. It begins on the day your coverage goes into effect and starts over each January 1. This is true for as long as you have coverage.

Coinsurance means the percentage of expenses you pay for covered services.

Contract means all of the following:

- any application you submitted for coverage;
- any agreement or group insurance policy we have with the policyholder;
- any application completed by the policyholder;
- this benefits certificate; and
- any riders or amendments.

Copayment is an amount you may be required to pay before Medicare or we will begin paying for benefits. A copayment is a set amount, rather than a percentage. For example, you might pay $20 or $50 for a doctor's visit or emergency room visit.

Covered Services means those medically necessary, Medicare approved services and supplies that qualify for payment of benefits under this certificate.

Deductible is an initial amount you must pay before Medicare or we will begin paying for benefits.

Emergency Care is care that is needed immediately because of an injury or an illness of sudden and unexpected onset.

Explanation of Medicare Benefits (EOMB) is a form summarizing the action Medicare took on your claim and what amount, if any, Medicare paid for the services you received.

Hospital means a facility that provides for the diagnosis, treatment and care of injured or sick persons. The facility must be licensed as a hospital under applicable law.

Illness or Injury means a bodily disorder, bodily injury, disease or mental illness. We will not provide benefits if your illness or injury falls under:

- motor vehicle no-fault plan;
- workers' compensation; or
- employer's liability or similar law, unless prohibited by law. This includes any injury you receive while you were working, while engaged in any activity pertaining to any trade, business,

employment or occupation for wage or profit.

Medicare is the Health Insurance for the Aged Act, Title XVIII of the Social Security Act of 1965 as originally passed and later amended.

Medicare Benefit Period counts the number of days under Medicare Part A you are covered for medically necessary services in a hospital or other facility primarily providing skilled or rehabilitation services. The benefit period begins on the first day you receive inpatient hospital services for which Medicare Part A allows benefits. The benefit period ends after you have been released from the hospital or nursing facility for 60 days in a row.

Medicare Eligible Expenses means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Nursing Facility provides continuous skilled nursing services as ordered and certified by your attending physician. A registered nurse (R.N.) must supervise services and supplies on a 24-hour basis. A nursing facility must also be licensed under applicable law.

Our means Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa.

Physician means a doctor of medicine (MD); doctor of osteopathy (DO); chiropractor; doctor of podiatric medicine (podiatrist); doctor of dental surgery or dental medicine (dentist); or doctor of optometry (optometrist).

Plan Member means you, the person who signed for this certificate and who pays the monthly premium or has the monthly premium paid by the policyholder on your behalf.

Policyholder means the entity or organization which sponsors this Employer Group Retiree Program and to whom we have issued a group insurance policy.

Provider means any licensed or approved health care professional including a physician, psychologist (who has a doctorate degree in psychology with two years clinical experience or who meets the standards of a national register), a chiropractor, optometrist, podiatrist, physical therapist, oral surgeon, certified registered nurse anesthetist, or any other provider approved by Medicare.

Us means Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa.

We means Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa.

You and Your means you, the plan member.